STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
175376			B. WING		08/13/2013			
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	'		
APOSTOLI	C CHRISTIAN HOME		511 PARAN SABETHA,					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
S 000	000 INITIAL COMMENTS			S 000				
	The following citations represent the findings of a Health Resurvey.		s of a					
S 970 SS=F			ility	S 970				
	(G) If a nursing facility uses a wireless system to meet the requirements of paragraphs							
	(i)(1)(A) through (E), all of the following additional requirements shall be met:							
	(i) The nursing facility shall be equipped with a system that records activated calls.		n a					
	(ii) A signal unanswered for a designated period of time, but not more than every three minutes, shall repeat and also be sent to another workstation or to staff that were not designated to receive the original call.							
	(iii) Each wireless system shall utilize radio frequencies that do not interfere with or disrupt pacemakers, defibrillators, and any other medical equipment and that receive only signals initiated from the manufacturer 's system.							
	The facility reported a resided on four halls. interview the pager sy	not met as evidenced be census of 85 resident Based on observation system for the wireless of trigger the licensed ses.	s that and call					
	Findings included:							
- Observation on 8/8/13 at 11:10 A.M. to pager triggered within 20 seconds of put								

If deficiencies are cited, an approved plan of correction is requisite to continued program participation. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATE FORM 621199 E1CF11 If continuation sheet 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	175376			B. WING		08/1	08/13/2013	
APOSTOLIC CHRISTIAN HOME 511 PAR.			511 PARAN	DRESS, CITY, STATE, ZIP CODE AMOUNT ST A, KS 66534				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE		
S 970	Continued From Page 1			S 970				
	call button. The licensed staff pager triggered at 5 minutes.							
	Administrative nurse D on 8/9/13 at 2:40 PM stated the call light system notified the charge nurses and the Director of Nursing when a call light was not answered within 4 minutes.							
	The facility's wireless call system did not escalate to additional staff within 3 minutes.							
S 972 SS=F	26-40-302 (H) P E - Nursing facility support systems			S 972				
	(H) The nursing facility 's preventative maintenance program shall include the testing of the call system at least weekly to verify operation of the system.							
	This Requirement is not met as evidenced by: The facility identified a census of 85 residents. Based on observation, record review, and staff interview, the facility failed to implement a weekly preventative maintenance program for the wireless call system.							
	Findings included:							
	- Observation on 8/6/13 while checking call lights on the nursing unit between 11:40 A.M. to 12:00 P.M. revealed 2 bathroom call lights on the 100 hall did not alert on the pager or above the doorway. Maintenance staff was made aware of the call light not functioning.							
	Observation on 8/8/13 approximately 10:59 A.M. during the environmental tour, revealed one of the two bathroom call lights from 8/6/13 did not light above the residents' doorway or on the pager.							

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATE FORM 621199 E1CF11 If continuation sheet 2 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	175376			B. WING		08/	08/13/2013	
	OVIDER OR SUPPLIER C CHRISTIAN HOME		STREET ADD 511 PARAM SABETHA,		ATE, ZIP CODE	•		
(X4) ID PREFIX TAG	•		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	(X5) COMPLETE DATE			
S 972	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 2012) Continued From Page 2 Interview with maintenance staff FF on 8/8/13 11:50 A.M. said he/she was unsure how often facility checked the call lights. He/she said he was unaware of any call light log showing whe maintenance staff checked the call lights. Interview with administrative nursing staff D on 8/12/13 at 10:55 A.M. revealed he/she visited maintenance staff EE and the resident room of lights were checked monthly. He/she said the facility faxed the log for the months of May, July 2013 and that was what it revealed at The facility failed to test the wireless call systeleast weekly.		en the he/she hen on ed with n call lee June, I also.	S 972	DEFICIE	NCT)		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.